DWC-AD 10133.53 NOTICE OF OFFER OF MODIFIED OR ALTERNATIVE WORK
For injuries occurring on or after 1/1/04

THIS SECTION COMPLETED BY *~~EMPLOYER OR~~* CLAIMS ADMINISTRATOR:

Employer (name of firm)_____ is offering you the position of a

(name of job) _____.

You may contact _____ concerning this offer. Phone No.: _____

Date of offer: _____ Date job starts: _____.

Claims Administrator:_____Claim Number:_____

NOTICE TO EMPLOYEE Name of employee: _____

Date of Injury:_____Date offer received: _____

You have 30 calendar days from receipt to accept or reject ~~this~~ the attached offer of modified or alternative work. Regardless of whether you accept or reject this offer, *the remainder of* your permanent disability ~~*award*~~ *payments* may be decreased by 15%. However, if ~~I~~f you fail to respond in 30 days or reject this job offer, you will not be entitled to the supplemental job displacement benefit unless:

~~**Modified Work**~~

~~A. The proposed modification(s) to accommodate required work restrictions are inadequate.~~
~~B. The modified job will not last 12 months.~~

Modified Work ☐ **or Alternative Work** ☐

A. You cannot perform the essential functions of the job; or
B. The job is not a regular position lasting at least 12 months; or
C. Wages and compensation offered ~~were~~ are less than 85% paid at the time of injury; or
D. The job is beyond a reasonable commuting distance from residence at time of injury.

THIS SECTION TO BE COMPLETED BY EMPLOYEE

__ I accept this offer of Modified or Alternative work.

__ I reject this offer of Modified or Alternative work and understand that I am not entitled to the Supplemental Job Displacement Benefit.

I understand that if I voluntarily quit prior to working in this position for 12 months, I ~~am~~ may not be entitled to the Supplemental Job Displacement Benefit.

_____ Date _____

Signature

I feel I cannot accept this offer because:

NOTICE TO THE PARTIES

If the offer is not accepted or rejected within 30 days of the offer, the offer is deemed to be rejected by the employee.

The employer or claims administrator must forward a completed copy of this agreement to the Administrative Director within 30 days of acceptance or rejection.

If a dispute occurs regarding the above offer or agreement, either party may request the Administrative Director to resolve the dispute by filing a Request for Dispute Resolution (Form DWC-AD 10133.~~54~~55) with the Administrative Director.

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POSITION REQUIREMENTS

Actual job title:

Wages: $ per Hour ___ Week ___ Month ___

Is salary of modified/alternative work the same as pre-injury job? Yes ___ No ___

Is salary of modified/alternative work ~~within 15%~~ at least 85% of pre-injury job? Yes ___ No ___

Will job last ~~more than~~ at least 12 months? Yes ___ No ___

Is the job a regular position required by the employer's business? Yes ___ No ___

Work location: _____

Duties required of the position:

Description of activities to be performed (if not stated in job description):

Physical requirements for performing work activities (include modifications to usual and customary job):

~~*Permanent and Stationary date: _____ Determined by:*~~

Name of doctor who approved job restrictions (optional)~~*Doctor's name:*~~ _____ Date of report: _____
~~*Date of Findings and Award:*~~ _____

Date of last payment of Temporary Total Disability~~*?*~~ *:* _____

Preparer's Name:

Preparer's Signature: Date